MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11190 CERTIFICATE OF DEATH

11180

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1mo 9days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Walkersville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clinton Middle: August Last: Baugher

4. DATE OF DEATH: Month: 11 Day: 12 Year: 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-17-80
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Baugher ~~not known~~
14. MOTHER'S MAIDEN NAME: Sarah Shankle ~~not known~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): General arteriosclerosis — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension. C.B.S. due to cerebral arteriosclerosis & psychosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-3, 19 56 to 11-12, 19 56, that I last saw the deceased alive on 11-11, 19 56, and that death occurred at 6 25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 11/12/56
PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 14, 1956
22c. NAME OF CEMETERY OR CREMATORY: Glade Cemetery
22d. LOCATION (City, town, or county) (State): Walkersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: G. C. Barton
ADDRESS: Walkersville, Md.
24a. REC'D BY REGISTRAR DATE: 15 Nov. 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Myers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11191

11181

Reg. Dist. No. 7H

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Marian — Middle: Brown — Last: Berry

4. DATE OF DEATH Month: November — Day: 1 — Year: 1956

5. SEX F. — 6. COLOR OR RACE W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH Aug. 20, 1877 — 9. AGE (In years last birthday) 79 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife — 10b. KIND OF BUSINESS OR INDUSTRY Home — 11. BIRTHPLACE (State or foreign country) Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Lloyd A. Brown — 14. MOTHER'S MAIDEN NAME Rebecca Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. None — 17. INFORMANT Address: Mr E. L. Berry - Sykesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH not known

592 X

DUE TO (b) Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/20, 1926, to 10/31/1, 1926 that I last saw the deceased alive on 10/31/56, 19, and that death occurred at 1125 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm. E. Martin M.D. — ADDRESS (Street, city or town, state) Randallstown Md — DATE SIGNED 11/3/56

PHYSICIAN'S NAME (Type) WM. E. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF 11-4-56 — 22c. NAME OF CEMETERY OR CREMATORY Springfield — 22d. LOCATION (City, town, or county) (State) Sykesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Luther N. Haight — ADDRESS Sykesville, Md. — 24a. REC'D BY REGISTRAR DATE 11-3-56 — 24b. REGISTRAR'S SIGNATURE C. Harry Crew

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11182

11192 **CERTIFICATE OF DEATH**

Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville

c. LENGTH OF STAY IN 1b since 4-11-53

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital

d. STREET ADDRESS ----

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle Thomas Last BRICE

4. DATE OF DEATH Month November Day 6 Year 1956

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH unknown

9. AGE (In years last birthday) 83 ?yrs.

IF UNDER 1 YEAR Months — Days —

IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Thurmont, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----

16. SOCIAL SECURITY NO. unknown

17. INFORMANT Address Sykesville, Md. Records of Springfield State Hospt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Generalized arteriosclerosis with hypertension — more than 3 yrs.

DUE TO

(c) ----

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ---- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----

20f. (City or town) (County) (State) ----

21. I certify that I attended the deceased from Feb. 18 1955, to Nov. 6th 1956 that I last saw the deceased alive on Nov. 6th 1956, and that death occurred at 10:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Martin Gross M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/7/56

PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Nov. 10-1956

22c. NAME OF CEMETERY OR CREMATORY U.B.Cem.

22d. LOCATION (City, town, or county) (State) Thurmont Frenk. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Eyerly ADDRESS Thurmont. MD

24a. REC'D BY REGISTRAR DATE NOV 9 1956

24b. REGISTRAR'S SIGNATURE C. Harry Keefer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) ISM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11183

11193 CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Finksburg~~ Hampstead
c. LENGTH OF STAY IN 1b: 26 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ~~Carrollton Rd~~ Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg Rural
d. STREET ADDRESS: Carrollton Rd
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Edmund Middle HARRISON Last Burk

4. DATE OF DEATH: Month November Day 19 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 26, 1902

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer.

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edmund A. Burk

14. MOTHER'S MAIDEN NAME: Ida M Bolte

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-05-4486

17. INFORMANT: Mrs Edmund Burk. Address: Finksburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Suddenly
DUE TO (b): Auricular Fibrillation — (?)
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 17, 1956, to Nov 17, 1956, that I last saw the deceased alive on Nov 17, 1956, and that death occurred at 9:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E. Bush M.D. — ADDRESS (Street, city or town, state): Hampstead Md — DATE SIGNED: 11-17-56

PHYSICIAN'S NAME (Type): Joseph E. Bush. MD — Hampstead Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 20/56

22c. NAME OF CEMETERY OR CREMATORY: St Pauls

22d. LOCATION (City, town, or county) (State): Balto Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw L Tipton — ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: 11/18/56

24b. REGISTRAR'S SIGNATURE: Henry J Reed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11184

CERTIFICATE OF DEATH

11194

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: ---

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: since 3-29-56

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 1550 Montpelier Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marshall — Middle: Rowe — Last: CARNEAL

4. DATE OF DEATH: Month: November — Day: 13 — Year: 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 4, 1881

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor on streetcar

10b. KIND OF BUSINESS OR INDUSTRY: --- Unk

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: James C. Carneal

14. MOTHER'S MAIDEN NAME: Madora Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records of Springfield State Hospital — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Abscess of the right kidney	about a month
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Abscess of the left lung	about one month.
DUE TO		
(c)	Bronchopneumonia	4 days

521X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychosis with senile brain disease - about 6 yrs.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): --- ---

20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from July 3, 1956, to November 12, 1956, that I last saw the deceased alive on November 12, 1956, and that death occurred at 8:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11/13/56

PHYSICIAN'S NAME (Type): Martin Gross, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-16-56

22c. NAME OF CEMETERY OR CREMATORY: Tarnum Baptist

22d. LOCATION (City, town, or county) (State): Warsaw Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Cook Inc — ADDRESS: 1217 St. Paul St.

24a. REC'D BY REGISTRAR DATE: 11-13-56

24b. REGISTRAR'S SIGNATURE: C. Haig Mace

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11185

11187

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 9yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 164 W. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
d. STREET ADDRESS 164 W. Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LOUISE Middle MORGAN Last CHAMPNESS

4. DATE OF DEATH Month Nov. Day 3 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH Dec 30, 1886
9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home-wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bernard Regan
14. MOTHER'S MAIDEN NAME Elizabeth Sherwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Miss Hild Regan Address 164 W. Main St. Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Valvular heart disease — INTERVAL BETWEEN ONSET AND DEATH 15 yrs
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 421.4
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 19 46 to Nov 3, 19 56 that I last saw the deceased alive on Nov 2, 19 56, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE E Reese Wilkens, M.D. ADDRESS (Street, city or town, state) Westminster DATE SIGNED 11/3/56

PHYSICIAN'S NAME (Type) D.E. Reese Wilkens

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Nov. 6-56
22c. NAME OF CEMETERY OR CREMATORY Louden Park
22d. LOCATION (City, town, or county) (State) Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.E. Myers Jr. Westminster Md.
24a. REC'D BY REGISTRAR DATE 11-5-56
24b. REGISTRAR'S SIGNATURE Harriet Shriller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11186

11195 CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 27 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18
d. STREET ADDRESS: 3955 Greenmount Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle; Last: CHESNUT

4. DATE OF DEATH: Month: 11; Day: 14; Year: 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ~~Unknown~~ 9/22/1886

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ~~Unknown~~ Willaim Chesnut

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Mary Jane ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Ye~~Unknown~~ (If yes, give war or dates of service): W W I

16. SOCIAL SECURITY NO.: ~~Unknown~~ Y

17. INFORMANT: Address: ss Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration pneumonia
491 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with arteriosclerosis psychotic reaction. Bronchopneumonia. Multiple abrasions of face

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 18, 1956, to November 14, 1956 that I last saw the deceased alive on November 14, 1956, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/19/56

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Moran ADDRESS: 3000 E. Baltimore St.

24a. REC'D BY REGISTRAR DATE: NOV 16 1956

24b. REGISTRAR'S SIGNATURE: C. Kerry Hays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11187

11196 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 mos.;8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 9301 Ocala St.
d. STREET ADDRESS: Silver Spring, Maryland.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15-56-2

3. NAME OF DECEASED (Type or print): First Emanuele — Middle — Last DeCARLO

4. DATE OF DEATH: Month November — Day 23 — Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 19, 1877
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch repairs
10b. KIND OF BUSINESS OR INDUSTRY: Jewelry store
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? ~~Unknown~~ U.S.A.

13. FATHER'S NAME: Nicholas DeCarlo
14. MOTHER'S MAIDEN NAME: Rosa Maria -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-36-1814
17. INFORMANT — Address: Springfield State Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years.

422.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 15, 1956, to November 23, 1956, that I last saw the deceased alive on November 23, 1956, and that death occurred at 3:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11/23/56

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/26/56
22c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Dunphrey — ADDRESS: 8434 Georgia Ave. S.S.Md.
24a. REC'D BY REGISTRAR DATE: 11-28-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11188

Reg. Dist. No. 76

11197

1. PLACE OF DEATH
a. COUNTY: CARROLL CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER
c. LENGTH OF STAY IN 1b: 27 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WESTMINSTER R.D.#7

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER R.D.#7
d. STREET ADDRESS: TANEYTOWN RD.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First LINNIE Middle BELLE Last DUVALL

4. DATE OF DEATH: Month NOV. Day 25 Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: DEC. 14, 1878

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARSTON CARROLL CO. Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: NATHANIEL ZILE

14. MOTHER'S MAIDEN NAME: ALICE POOLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: ALBIN N. DUVALL Address: RD#7 WESTMINSTER, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH: 5 mos
237 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ a. m. p. m. Month ____ Day ____ Year 19____

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 23 1956 to Nov. 25 1956 that I last saw the deceased alive on Nov. 6 1956 and that death occurred at 2:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Reese Wilkens M.D. ADDRESS (Street, city or town, state): Westminster DATE SIGNED: 11/26/56

PHYSICIAN'S NAME (Type): E. Reese WILKENS Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV. 28, 56

22c. NAME OF CEMETERY OR CREMATORY: STONE CHAPEL CEM.

22d. LOCATION (City, town, or county) (State): RURAL, WESTMINSTER, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: K. S. Myers Jr. ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: 11-26-56

24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11189

11198

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR RURAL
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SAMS CREEK

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR RURAL
d. STREET ADDRESS: SAMS CREEK
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First SUSAN Middle ELIZABETH Last ECKER

4. DATE OF DEATH: Month NOV Day 15 Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: NOV 25 - 1881

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY FRITZ

14. MOTHER'S MAIDEN NAME: SARAH LAMBERT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ALBERT ECKER Address: NEW WINDSOR RURAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardiovascular disease — Years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 8, 1956, to Nov 15, 1956, that I last saw the deceased alive on Nov 15, 1956, and that death occurred at 8:45 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T Marsh M.D. ADDRESS (Street, city or town, state): Westminster Md DATE SIGNED: 11/16/56

PHYSICIAN'S NAME (Type): JAMES T. MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Nov 17-1956

22c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK

22d. LOCATION (City, town, or county) (State): CARROLL CO. MD

23. FUNERAL DIRECTOR'S SIGNATURE: D D Hartzler & Sons ADDRESS: New Windsor

24a. REC'D BY REGISTRAR DATE: Nov 17/56

24b. REGISTRAR'S SIGNATURE: Ernest S Bunchet

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11199 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 11190

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 12yr;1mo.13days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Route 4
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Denton — Middle: Smith — Last: EDWARDS

4. DATE OF DEATH: Month: November — Day: 15 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18, 1905

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Henry Edwards

14. MOTHER'S MAIDEN NAME: Mary Crim

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 - 4 days.
491X
DUE TO (b): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old contusion focus of right frontal lobe of brain. Meningo vascular syphilis-

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in epileptic seizure

20c. TIME OF INJURY: Hour: — o. m. p. m. — Month, Day, Year: — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town): Sykesville (County): Carroll (State): Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): James T. Marsh, M.D. — Nov. 15, 1956.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-17-56
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: 11-17-56

24b. REGISTRAR'S SIGNATURE: C. Harry Edw

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11191

11200 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Westminster
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Westminster
d. STREET ADDRESS: R.D. #6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUSSELL — Middle C. — Last FOWLER

4. DATE OF DEATH: Month 11 — Day 19 — Year 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6 -26-1901

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William C. Fowler

14. MOTHER'S MAIDEN NAME: Bertie Cushing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218 14 7175

17. INFORMANT: Mrs. Elva M. Fowler, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
420.1
DUE TO
(b): Coronary thrombosis — minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 10, 1949, to Nov 19, 1956, that I last saw the deceased alive on Nov 19, 1956, and that death occurred at 4:08 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Julius Chepko, M.D. — ADDRESS (Street, city or town, state): 85½ W. Main Westminster Md — DATE SIGNED: 11/19/56

PHYSICIAN'S NAME (Type): JULIUS CHEPKO

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-23-1956

22c. NAME OF CEMETERY ~~OR CREMATORY~~: St. James

22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Maryland

24a. REC'D BY REGISTRAR DATE: 11-21-56

24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11192

11201 **CERTIFICATE OF DEATH**

Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3yrs.,10mos.,23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Thurmont
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Eli — Last GREEN

4. DATE OF DEATH: Month November — Day 13 — Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 17, 1902
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Clayton Green
14. MOTHER'S MAIDEN NAME: Laura Hannah Zimmerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT — Address: Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary embolism, left lung — INTERVAL BETWEEN ONSET AND DEATH: minutes

464X

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Thrombophlebitis of left iliac veins — 2 days

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with intracranial infection, post-encephalitic. Parkinson's Disease.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 20, 1952 to November 13, 1956, that I last saw the deceased alive on November 13, 1956, and that death occurred at 9:20A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11/13/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: II-16*1956
22c. NAME OF CEMETERY OR CREMATORY: Utica Cem.
22d. LOCATION (City, town, or county) (State): Utica, Fredk Co., MD

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager — ADDRESS: Thurmont MD

24a. REC'D BY REGISTRAR DATE: NOV 16 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11202

CERTIFICATE OF DEATH

11193

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 mos, 18 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 31
d. STREET ADDRESS: 410 S. Dallas Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Peter; Middle:; Last: GUZINSKI

4. DATE OF DEATH: Month: November; Day: 14; Year: 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1884

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10b. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alex Guzinski

14. MOTHER'S MAIDEN NAME: Ann Mrozosinski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-03-4152

17. INFORMANT: Springfield Hospital records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary arteriosclerosis — Years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 26, 1956, to November 14 1956, that I last saw the deceased alive on November 14, 1956, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 11/14/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-17-56
22c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: M. Fotadowski & Son
ADDRESS: 1808 Eastern Ave

24a. REC'D BY REGISTRAR DATE: 11-15-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11203

Reg. Dist. No. 11194

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3502 Southern Ave. Zone 14
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine; Middle: Marie; Last: HANDLER

4. DATE OF DEATH: Month: November; Day: 15; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 1, 1889

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clothing factory

10b. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christopher Handler

14. MOTHER'S MAIDEN NAME: Amelia Stockhausen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 218-28-4528

17. INFORMANT: Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Hours

465 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with arteriosclerosis, with questionable history of cerebral vascular accident. Parkinson's Disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 9, 1956, to November 15, 1956, that I last saw the deceased alive on November 15, 1956, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 11/15/56

PHYSICIAN'S NAME (Type): Edmund Lusthaus
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/19/1956
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Ruck
ADDRESS: 5305 Harford Road #14

24a. REC'D BY REGISTRAR DATE: 11-15-56
24b. REGISTRAR'S SIGNATURE: C. Hally Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11195

11204 **CERTIFICATE OF DEATH**

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b: 72 YRS.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: RD 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
d. STREET ADDRESS: R.D. 3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ESTIE Middle F. Last HARRIS

4. DATE OF DEATH: Month 11 Day 5 Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1884-5-1

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: ___

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JONAS UTZ

14. MOTHER'S MAIDEN NAME: SARAH E. HOUCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): ___

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Address: MRS CATHERINE WOLFE, HAMPSTEAD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary artery Disease — INTERVAL BETWEEN ONSET AND DEATH: 11 mo.
420.1
DUE TO (b): arteriosclerosis — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1st, 1954 to Nov 5th, 1956, that I last saw the deceased alive on Nov 3rd, 1956, and that death occurred at 4 a.m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C Billingslea M.D. ADDRESS (Street, city or town, state): Westminster, Md. DATE SIGNED: 11-6-56

PHYSICIAN'S NAME (Type): C. L. Billingslea

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-8-1956

22c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. PANGEMI

22d. LOCATION (City, town, or county) (State): MANCHESTER, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: H BANKARD & SON ADDRESS: WESTMINSTER, MD.

24a. REC'D BY REGISTRAR DATE: 11-9-56

24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11196

11205 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Balto. City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 12 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: 4318 Wilkshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna Middle Theresa Last Hofherr
4. DATE OF DEATH: Month November Day 1 Year 1956

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-29-1878
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore Hofherr
14. MOTHER'S MAIDEN NAME: Adelaide Imwald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT — Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): massive arterial embolism left iliac artery — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
334x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. due to cerebral arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-19-56, 19____, to October 31, 1956, that I last saw the deceased alive on October 31, 1956, and that death occurred at 5:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 11/1/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/5/56
22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Ruck ADDRESS: 5305 Harford Rd
24a. REC'D BY REGISTRAR DATE: 11-1-56
24b. REGISTRAR'S SIGNATURE: C. Henry Lee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11188

11197

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster

LENGTH OF STAY (In this place): 40 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 213 E. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Carroll

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster

STREET ADDRESS (If rural give location): 213 E. Green St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Franklin (Last) Humbert

4. DATE OF DEATH (Month) Nov. (Day) 23 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	February 24, 1870	86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rt Laborer	Blacksmith	Carroll County, Maryland	U S A

13. FATHER'S NAME: William Humbert

14. MOTHER'S MAIDEN NAME: Eva Wentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		212-32-3725	Mrs. Emma Humbert Westminster, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs

ANTECEDENT CAUSE(S) DUE TO (B) A. S. C. V. disease — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/22/56 19..., to 11-23, 1956, that I last saw the deceased alive on 11-23, 1956, and that death occurred at 11 P M, from the causes and on the date stated above.

SIGNATURE James G Shamer M.D. ADDRESS (Street, city/town, state) Westminster Md DATE SIGNED 11/24/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/26/56	Silver Run Cemetery	Silver Run, Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE 11-26-56	Hamet Miller	John R. Byers Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11198

11206 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 4mo. 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rogers Forge, Maryland
d. STREET ADDRESS: 425 Murdock Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis; Middle: Joseph; Last: Huppman

4. DATE OF DEATH: Month: Nov.; Day: 28; Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-17-92

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Phillip Huppman

14. MOTHER'S MAIDEN NAME: Mary (Melina) Wirth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
420.1
DUE TO (b): Myocardial Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with arteriosclerosis with psychotic reaction (cerebral)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/12, 1956, to 11/28, 1956, that I last saw the deceased alive on 11/28, 1956, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrude M. Gross, M.D. M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11/28/1956

PHYSICIAN'S NAME (Type): Gertrude M. Gross, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/1/56
22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Ruck — ADDRESS: 530 Harford Rd

24a. REC'D BY REGISTRAR DATE: 11-29-56
24b. REGISTRAR'S SIGNATURE: C. Harry Meier

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11207 CERTIFICATE OF DEATH

11199
Reg. Dist. No. 16

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster, Myers Dist.

c. LENGTH OF STAY IN 1b: Life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Littlestown, Pa. R. D. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster, Myers District

d. STREET ADDRESS: Mailing Address Littlestown, Pa. R. D. 1

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Ida — Middle: —— Last: Koontz

4. DATE OF DEATH: Month: 11/7/56 — Day — Year: 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 12/15/1856

9. AGE (In years last birthday): 99 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife, Housework

10b. KIND OF BUSINESS OR INDUSTRY: Her own home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jesse Rinaman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT George Koontz Address: George Koontz, Littlestown, Pa. R.D.1 Carroll Co.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
334x

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Metabolic Deficiencies & Inanition — 1 month
DUE TO
(c): Cerebral Arteriosclerosis — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Decubitus Ulcer on Left Hock with Cellulitis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/22, 19 49, to 11/7, 19 56, that I last saw the deceased alive on 11/7, 19 56, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald E. Piper, M.D. — ADDRESS (Street, city or town, state): Taneytown, Md. — DATE SIGNED: 11/8/56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/10/56

22c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

22d. LOCATION (City, town, or county) (State): Silver Run, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Little — ADDRESS: Littlestown, Pa.

24a. REC'D BY REGISTRAR DATE: 11-6-56

24b. REGISTRAR'S SIGNATURE: Hazel Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

11205

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: 1 YEAR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BROADWAY

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: BROADWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ARBY — Middle: MONROE — Last: LAMANCE

4. DATE OF DEATH: Month: NOV — Day: 24 — Year: 1956

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	MARRIED ☒	JULY 18- 1911	45 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ROOFING CONTRACTOR	CONSTRUCTION	TEXAS	USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	526-07-6142	BLANCHE LAMANCE UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 10 MIN.

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 11/24/56

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	NOV 27- 1956	LINGANORE	UNIONVILLE MD

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: D D Hartzler & Sons Union Bridge Md

24a. REC'D BY REGISTRAR DATE: NOV 28 1956

24b. REGISTRAR'S SIGNATURE: Leslie L Repp

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201

11209 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4605 Arabia Ave., Balto. 14, Md.
d. STREET ADDRESS: Baltimore, Maryland.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Caroline — Middle: Kerber — Last: LAUMANN
4. DATE OF DEATH: Month: November — Day: 20 — Year: 1956
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 12, 1878
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Floor lady
10b. KIND OF BUSINESS OR INDUSTRY: Store
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: - Kerber
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT — Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 23, 1956, to November 20, 1956, that I last saw the deceased alive on November 20, 1956, and that death occurred at 8:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield Hospital — DATE SIGNED: 11/20/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/24/56
22c. NAME OF CEMETERY OR CREMATORY: LORDDINE
22d. LOCATION (City, town, or county) (State): WOODLAWN MD

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: ULLRICH FUNERAL HOME 4210 BELAIR
24a. REC'D BY REGISTRAR DATE: 11-20-56
24b. REGISTRAR'S SIGNATURE: C. Harry Klein

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11202

11210 **CERTIFICATE OF DEATH**

Reg. Dist. No. 26

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Nr. Westmister

LENGTH OF STAY (in this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: (Myers District) Westminster, Md. R. D. 2

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Carroll

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Nr. Westminster

STREET ADDRESS (If rural give location): Myers Dist. Westminster, Md. R. D. 2

3. NAME OF DECEASED (Type or Print): (First) Maurice (Middle) Clayton (Last) Leister

4. DATE OF DEATH (Month) (Day) (Year): 11/17/56 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	2/28/1883	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet Maker	Cabinet Shop	Carroll Co., Md.	U.S.A.

13. FATHER'S NAME: Aaron Leister

14. MOTHER'S MAIDEN NAME: Sofia Louey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) 1/12/04 - 1/11/07

16. SOCIAL SECURITY NO.: 219-01-8001

17. INFORMANT & ADDRESS: Mrs Lila M. Leister — Mrs. Lila M. Leister, Westminster, Md. R-2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSE(S) DUE TO (B): Arteriosclerotic Cardio-Vascular disease — 2 year +

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-30, 1956, to 11-17, 1956, that I last saw the deceased alive on 11-7, 1956, and that death occurred at 5 P M, from the causes and on the date stated above.

SIGNATURE: James L. Mood M.D. — ADDRESS (Street, city, town, state): Westminster Md — DATE SIGNED: 11/17/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/20/56	St. Marys Cemetery	Silver Run, Carroll Co., Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 11-20-56	Hazel H. Miller	Richard A. Little	Littlestown, Pa.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11203

11211 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: since 7-27-55
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ———
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 24
d. STREET ADDRESS: 116 Rochester Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Andrew — Last Martin

4. DATE OF DEATH: Month November — Day 11 — Year 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5 - 10 - 1878

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months ——— Days ———
IF UNDER 24 HRS.: Hours ——— Min. ———

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tile Setter

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Martin

14. MOTHER'S MAIDEN NAME: Mahn, ~~Mary~~ A. Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service) No ———

16. SOCIAL SECURITY NO.: 220-18-6634

17. INFORMANT: Records of Springfield State Hospital — Address Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Edema of the lungs	4 hours
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Cerebro- vascular accident	2 weeks
DUE TO (c)	Generalized arteriosclerosis	2 years more than

331 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome associated with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. ——— Month, Day, Year ——— 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 22, 1955, to Novemb. 11, 1956, that I last saw the deceased alive on Novemb. 11, 1956, and that death occurred at 2:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11-11-56

PHYSICIAN'S NAME (Type): Martin Gross, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/14/56

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Moran — ADDRESS: 3000 E. Baltimore Street

24a. REC'D BY REGISTRAR DATE: NOV 14 1956

24b. REGISTRAR'S SIGNATURE: C. Barry Keerg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11212 CERTIFICATE OF DEATH

Reg. Dist. No. 11204 75

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
c. LENGTH OF STAY IN 1b one week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Long View Nurs Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First R - Middle VALERIA - Last MARTIN

4. DATE OF DEATH Month Nov Day 3 Year 19 56

5. SEX F — 6. COLOR OR RACE W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH May 18-1910 — 9. AGE (In years last birthday) 46 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife — 10b. KIND OF BUSINESS OR INDUSTRY Own home — 11. BIRTHPLACE (State or foreign country) Md — 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Richard Tracey — 14. MOTHER'S MAIDEN NAME Elsie Wilhelm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — — 17. INFORMANT Address Richard Tracey, Upperco Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lungs — INTERVAL BETWEEN ONSET AND DEATH 6 mo

DUE TO (b) Carcinoma of Rectum — 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 154X

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1956, to Nov 3, 1956, that I last saw the deceased alive on Nov. 2, 1956, and that death occurred at 3:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE M.C. Porterfield M.D. — ADDRESS (Street, city or town, state) Hampstead, Md — DATE SIGNED 11-3-56

PHYSICIAN'S NAME (Type) M.C. Porterfield — Hampstead, Md. — 11/3/56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF Nov 6-1956 — 22c. NAME OF CEMETERY OR CREMATORY Mt Zion — 22d. LOCATION (City, town, or county) (State) Bultimore Md

23. FUNERAL DIRECTOR'S SIGNATURE Edw C Upton — ADDRESS Hampstead Md — 24a. REC'D BY REGISTRAR DATE Nov 6-56 — 24b. REGISTRAR'S SIGNATURE Mrs. H.P.S. Donner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG207 11-26-56 et

CERTIFICATE OF DEATH

11213

Reg. Dist. No. 11205 54

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.1mo.23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 616 Melville Ave.,Balto.18,Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle William — Last McClinchey

4. DATE OF DEATH: Month November — Day 15 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 16, 1900

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Connecticut

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. McClinchey

14. MOTHER'S MAIDEN NAME: Annie Finley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Springfield State Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
581.0
DUE TO
(b): Cirrhosis of liver — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with alcohol intoxication without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 22, 1955, to November 15, 1956, that I last saw the deceased alive on November 15, 1956, and that death occurred at 8:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11/16/56

PHYSICIAN'S NAME (Type): AGUSTIN DEL CAMPO — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/19/1956

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ellsworth Cremeens — ADDRESS: 4000 Liberty Heights Ave.

24a. REC'D BY REGISTRAR DATE: NOV 19 1956

24b. REGISTRAR'S SIGNATURE: C. Barry Keep

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11214

CERTIFICATE OF DEATH

11206
Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: since 5-5-55
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ---
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 1200 Valley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Middle Last: Leonard Jerome Augustine MILLER

4. DATE OF DEATH: Month Day Year: November 15th 1956

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-7-75
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months - Days
IF UNDER 24 HRS.: Hours - Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Albert Miller
14. MOTHER'S MAIDEN NAME: Elizabeth -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Records of Springfield State Hospital
Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchopneumonia - right side	3 days
491 X		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Gangrene of right lower leg	3 days
(c)	---	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychosis with senile brain disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---
20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from May 5, 1955, to Nov. 15, 1956 that I last saw the deceased alive on November 15th, 1956, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 11/16/56

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M. D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 19, 1956
22c. NAME OF CEMETERY OR CREMATORY: Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Rita Wiedefeld
ADDRESS: 900 E. Biddle St.
24a. REC'D BY REGISTRAR DATE: NOV 19 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Heun

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11215 **CERTIFICATE OF DEATH** Reg. Dist. No. 11207 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 10 days, 11mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, 31, 3 V 0 1 - 4
d. STREET ADDRESS: 2003 Gough Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Ernest — Last: MITCHELL
4. DATE OF DEATH: Month: November — Day: 19, — Year: 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 7, 1888
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edward E. Mitchell
14. MOTHER'S MAIDEN NAME: Louise E. - ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: ? -
17. INFORMANT — Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days
420.0
DUE TO (b): Arteriosclerotic heart disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Generalized arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 9, 1955, to November 19 1956, that I last saw the deceased alive on November 19, 1956, and that death occurred at 8:50A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11/19/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-21-56
22c. NAME OF CEMETERY OR CREMATORY: Springfield
22d. LOCATION (City, town, or county) (State): Sykesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Arthur A. Haight — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: 11-21-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11208

11216

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: Since 7.14.1921

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hosp

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First NANNIE Middle M. Last MOSER

4. DATE OF DEATH: Month 11 Day 11 Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5.10.1867

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: EZRA B. MOSER

14. MOTHER'S MAIDEN NAME: ROSANNA WALLICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs NANNIE M. HORN Address: Washington Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420.0

DUE TO (b): Arteriosclerotic Heart Disease — Several years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis — Many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenia of Paranoid Type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10. 6, 1956, to 11. 11., 1956, that I last saw the deceased alive on 11. 11., 1956, and that death occurred at 12 noon, from the causes and on the date stated above.

ACTUAL SIGNATURE: Valdis Aizkraukl M.D. ADDRESS (Street, city or town, state): Springfield St. Hosp DATE SIGNED: 11.11.1956

PHYSICIAN'S NAME (Type): VALDIS AIZKRAUKLIS M.D. Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 14. 1956

22c. NAME OF CEMETERY OR CREMATORY: Oakmont Cemetery

22d. LOCATION (City, town, or county) (State): near Mabelville Carr. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: East End. Home ADDRESS: Boonsboro Wash. Co. Md

24a. REC'D BY REGISTRAR DATE: NOV 14 1956

24b. REGISTRAR'S SIGNATURE: C Harry Myers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217 CERTIFICATE OF DEATH

Reg. Dist. No. 11209 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: since 8/26/52
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 232 E. Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

10-11-2

3. NAME OF DECEASED (Type or print): First: Virgie'a — Middle: Wolfe — Last: Null
4. DATE OF DEATH: Month: 11 — Day: 17 — Year: 1956
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1889, August 15
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~none~~ Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Department Store
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Wolfe
14. MOTHER'S MAIDEN NAME: Annie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unkn (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unkn
17. INFORMANT — Address: Hosp.Records & Son Ralph Null, Monongahela, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: hours

455X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Gangrenous decubitus ulcers — weeks

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome assoc.with cerebral arterioscler.with psych.react

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-20- 1954, to 11-17- 1956, that I last saw the deceased alive on 11-17- 1956, and that death occurred at 6:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 11-18-56

PHYSICIAN'S NAME (Type): Edmund Lusthaus — Sykesville, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 20 Nov 1956
22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Frederick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: M. R. Etchison & Son, Frederick, Maryland
24a. REC'D BY REGISTRAR — DATE: 11-20-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weir

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11218 CERTIFICATE OF DEATH

11210
Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE
c. LENGTH OF STAY IN 1b SINCE 5-9-55
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. STREET ADDRESS 3316 LAKE AVE. BALTO
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ANNA Middle Last OLTEAN

4. DATE OF DEATH Month 11 Day 3 Year 1956

5. SEX F
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH UNKNOWN
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN
11. BIRTHPLACE (State or foreign country) ROMANIA
12. CITIZEN OF WHAT COUNTRY? UNKNOWN

13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT Address SSH. SOCIAL SERVICE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO HYPERTENSION — INTERVAL BETWEEN ONSET AND DEATH ½ HOUR
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Disease, — YEARS
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS. — YEARS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCTOBER, 1955, to 11-3, 1956, that I last saw the deceased alive on 11-3, 1956, and that death occurred at 12:05 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Julian Radzykewycz M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED
PHYSICIAN'S NAME (Type) JULIAN RADZYKEWYCZ MD

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF NOV 6 1956
22c. NAME OF CEMETERY OR CREMATORY OAKLAWN
22d. LOCATION (City, town, or county) (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE R.F.C. & B.M. Walters ADDRESS Pratt & Stricker St.
24a. REC'D BY REGISTRAR DATE NOV 7 1956
24b. REGISTRAR'S SIGNATURE C. Harry Warp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

11219 11211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6yr, 11mo, 29dy
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 1622 North Calvert Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Adams; Last: PINKLER

4. DATE OF DEATH: Month: November; Day: 7; Year: 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/6/93

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Hosp

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph P. Pinkler

14. MOTHER'S MAIDEN NAME: Carrie Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Springfield Hospital records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subdural hemorrhage, right side — INTERVAL BETWEEN ONSET AND DEATH: 6 days
904.7
DUE TO (b): Fracture of skull, left side — 6 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with convulsive disorder with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Patient was found on floor unconscious

20c. TIME OF INJURY: Hour: X; o. m. / p. m.; Month, Day, Year: 11/2 1956

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town): Sykesville (County): Carroll (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/8/56

EXAMINER'S NAME (Type): James T. Marsh, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11.1[illegible], 56
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county): Baltimore (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: William Cook Inc 1217 St. Paul Street Balto2 Md

24a. REC'D BY REGISTRAR DATE: 11-9-56
24b. REGISTRAR'S SIGNATURE: C. Henry Wen

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11220

CERTIFICATE OF DEATH

11212

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.1mo.;17days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 518 S. Hanover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Samuel — Last PLETZER

4. DATE OF DEATH: Month November — Day 2 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 10, 1905

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Pletzer

14. MOTHER'S MAIDEN NAME: Annie Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): 1942-1943

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield State Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary tuberculosis,far advanced, active — INTERVAL BETWEEN ONSET AND DEATH: six years
002X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenia, paranoid type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 15, 1955 to November 2, 1956, that I last saw the deceased alive on November 1, 1956, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 11/2/56

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-5-56
22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J.D.Denny,Inc.,715 Light St., Balto., Md.

24a. REC'D BY REGISTRAR DATE: NOV 5 1956

24b. REGISTRAR'S SIGNATURE: C. Perry Hurst

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11189 — 11213 — Reg. Dist. No. 56

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation or removal.

1. PLACE OF DEATH — a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 10 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 92 PENNA. AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 92 PENNA. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MURTON — Middle: LEO — Last: REAVER
4. DATE OF DEATH: Month: NOV — Day: 1 — Year: 1956
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 28, 1900
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (State or foreign country): FRED. CO. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: M. HAMILTON REAVER
14. MOTHER'S MAIDEN NAME: FLORENCE HAINES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-18-2365
17. INFORMANT — Address: MRS. LEO REAVER, WESTMINSTER, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 5 MIN
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): JAMES T. MARSH
DATE SIGNED: 11/1/56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: NOV. 3, 1956
22c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEMETERY
22d. LOCATION (City, town, or county) (State): WESTMINSTER, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. S. Myers & Sons, Westminster, Md.
24a. REC'D BY REGISTRAR — DATE: 11-2-56
24b. REGISTRAR'S SIGNATURE: Hazel Miller

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11221 **CERTIFICATE OF DEATH**

Reg. Dist. No. 11214 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenelg 13 X - 2.
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Warren — Middle: Thomas — Last: RIDGLEY
4. DATE OF DEATH: Month: November — Day: 19 — Year: 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 19, 1881
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Ridgley
14. MOTHER'S MAIDEN NAME: Mary - Unk -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT — Address: Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — Interval between onset and death: Hours
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — Years
DUE TO
(c): General arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 6, 1956, to November 19 1956, that I last saw the deceased alive on November 19, 1956, and that death occurred at 1:33P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 11/19/56
PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-22-56
22c. NAME OF CEMETERY OR CREMATORY: Harmony
22d. LOCATION (City, town, or county) (State): Howard Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur A. Haight — ADDRESS: Lytleville, Md.
24a. REC'D BY REGISTRAR DATE: 11-20-56
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11222 **CERTIFICATE OF DEATH** 11215 82

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Airy

c. LENGTH OF STAY IN 1b: 2½ yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Park Avenue

d. STREET ADDRESS: Park Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Last: Rinker

4. DATE OF DEATH: Month: November Day: 27 Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 4, 1867

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: ? Lanom

14. MOTHER'S MAIDEN NAME: ? UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: -None-

17. INFORMANT: Mrs. Anna Mae Fowler (Daughter) Address: Mt. Airy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 8 years

450.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956, to November, 1956, that I last saw the deceased alive on November 21, 1956, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W.B. Culwell M.D. ADDRESS (Street, city or town, state): Mt. Airy, Md. DATE SIGNED: Nov 27, 1956

PHYSICIAN'S NAME (Type): W.B. Culwell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-30-1956

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Pine Grove

22d. LOCATION (City, town, or county) (State): Mt. Airy, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C.M. Waltz ADDRESS: Winfield, Md.

24a. REC'D BY REGISTRAR DATE: NOV 29 1956

24b. REGISTRAR'S SIGNATURE: Edna Hewitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11216

11223 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 16 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Long View Nursing Home.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Berlin — 75 X-3
d. STREET ADDRESS: R.F.D. #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Catherine — Last: Seibright
4. DATE OF DEATH: Month: November — Day: 8 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: May 20, 1865
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Kelter
14. MOTHER'S MAIDEN NAME: Elizabeth Border

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT — Address: Mrs. John Crawford, Hanover Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO (b): Arteriosclerotic Cardio-Renal Vas. Lesion
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 26, 1955, to Nov 8, 1956 that I last saw the deceased alive on Nov 8, 1956, and that death occurred at 12:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E. Bush M.D. — ADDRESS (Street, city or town, state): Hampstead Md — DATE SIGNED: 11-8-56
PHYSICIAN'S NAME (Type): Joseph E. Bush MD — HAMPSTEAD — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 11/56
22c. NAME OF CEMETERY OR CREMATORY: East Berlin cem
22d. LOCATION (City, town, or county) (State): Adams Co Md Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Edw C. Tipton. — ADDRESS: Hampstead Md
24a. REC'D BY REGISTRAR DATE: Nov. 10-56
24b. REGISTRAR'S SIGNATURE: Mrs. H.P.L. Demmer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217

11224 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
c. LENGTH OF STAY IN 1b 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
d. STREET ADDRESS Oakland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ANNA Middle E Last SMITH

4. DATE OF DEATH Month Nov Day 27 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-16-1899
9. AGE (In years last birthday) 57 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Earl Jenkins
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Jesse E. Smith - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest, Coronary Thrombosis, — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hypertension, Obesity. — 36 hours

DUE TO (c) — To 27 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 1956, to 27 Nov, 1956, that I last saw the deceased alive on 27 Nov, 1956, and that death occurred at 6:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Howard E. Hall M.D. ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 27 Nov 56

PHYSICIAN'S NAME (Type) HOWARD E HALL SYKESVILLE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-30-56
22c. NAME OF CEMETERY OR CREMATORY Granite Presbyterian
22d. LOCATION (City, town, or county) (State) Granite, Balto. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE Fielded N. Haight ADDRESS Sykesville, Md.
24a. REC'D BY REGISTRAR DATE 11-28-56
24b. REGISTRAR'S SIGNATURE C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G207, 11/23/56 bh

11225 **CERTIFICATE OF DEATH** 11218

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 v 01-4
d. STREET ADDRESS 4106 Belle Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ELSIE Middle R. Last SMITH
4. DATE OF DEATH Month 11 Day 11 Year 1956

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 9.27.1885
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME DANIEL J. ROBERTS
14. MOTHER'S MAIDEN NAME LAURA REMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address 535 Piccadilly Mrs William L. RICHARDSON Balto 4, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2
DUE TO (b) Nonspecific Myocardial Disease — several years
~~DUE TO~~ (c) and Pleurisy Left Side. — 8 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Manic Depressive Psychosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-25 19 41 to 11-10 19 56, that I last saw the deceased alive on 11-10 19 56, and that death occurred at 1 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE Gertrud Sonnenfeldt M.D. ADDRESS (Street, city or town, state) Springfield State Hospital Md. DATE SIGNED
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/13/56
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem
22d. LOCATION (City, town, or county) (State) Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William J. Tickner & Sons ADDRESS Balto Md.
24a. RECD BY REGISTRAR DATE Nov. 15, 1956
24b. REGISTRAR'S SIGNATURE C. Harry Keers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11226 — 11219 — Reg. Dist. No. 71

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIONTOWN RURAL
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANDOVER
d. STREET ADDRESS: 604 WARREN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RUSSELL — Middle: MOSES — Last: SMITH

4. DATE OF DEATH: Month: NOV — Day: 24 — Year: 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JULY 8 - 1932

9. AGE (In years last birthday): 24 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK HELPER

10b. KIND OF BUSINESS OR INDUSTRY: GROCERY TRUCKS

11. BIRTHPLACE (State or foreign country): CARROLL CO. MD

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: MERTON THOMAS

14. MOTHER'S MAIDEN NAME: SARAH FRITZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-30-6616

17. INFORMANT: BETTY SMITH — Address: LANDOVER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): GUNSHOT WOUND of Head — INTERVAL BETWEEN ONSET AND DEATH: NONE
919.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): GUNSHOT - ACCIDENTAL - HUNTING

20c. TIME OF INJURY: Hour: — o. m. / p. m. — Month, Day, Year: 11-24 1956

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): FARM

20f. (City or town) (County) (State): Uniontown Carroll Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES T MARSH

DATE SIGNED: 11/25/56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV 27 - 1956

22c. NAME OF CEMETERY OR CREMATORY: LUTHERAN

22d. LOCATION (City, town, or county) (State): UNIONTOWN MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: D D Hartzler & Sons, New Windsor, Md

24a. REC'D BY REGISTRAR DATE: NOV 28 1956

24b. REGISTRAR'S SIGNATURE: Margaret England

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11220

11227 **CERTIFICATE OF DEATH**

Reg. Dist. No. 15

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Lineboro
c. LENGTH OF STAY IN 1b 65yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION R.D.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore. Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Lineboro.
d. STREET ADDRESS R.D.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First Levi Middle H. Last Sotdorus.

4. DATE OF DEATH Month November Day 22 Year 1956.

5. SEX Male
6. COLOR OR RACE W.
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH November 12 1868
9. AGE (In years last Birthday) 88. yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Glen Rock Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm H. Sotdorus.
14. MOTHER'S MAIDEN NAME Leah Ehrman.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Sarah L. Sotdorus Address Lineboro, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease 443X
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 1956, to Nov 22, 1956, that I last saw the deceased alive on Nov 15, 1956, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Paul D Shaub M.D. ADDRESS (Street, city or town, state) Shrewsbury, Pa. DATE SIGNED 11-24-56

PHYSICIAN'S NAME (Type) Paul D. Shaub. Shrewsbury, Pa.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Nov. 25 1956
22c. NAME OF CEMETERY OR CREMATORY Stultz Cemetery
22d. LOCATION (City, town, or county) (State) Glen Rock, Pa. R.D.3.

23. FUNERAL DIRECTOR'S SIGNATURE J. Jacob Hartenstein, New Freedom, Pa. ADDRESS
24a. REC'D BY REGISTRAR DATE NOV 27 1956
24b. REGISTRAR'S SIGNATURE Mrs. H. K. S. Denues

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11228 **CERTIFICATE OF DEATH** 11221 Reg. Dist. No. 81

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: ELGER ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: ELGER ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle ELLSWORTH Last WILSON

4. DATE OF DEATH: Month NOV Day 20 Year 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 15 - 1873

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: TENENT

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JACOB WILSON

14. MOTHER'S MAIDEN NAME: JENNIE WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 218-24-1458

17. INFORMANT: STERLING WILSON — Address: UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Arteria Sclerosis
DUE TO
(c):

422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-16, 1956, to 11-19, 1956, that I last saw the deceased alive on 11-19-, 1956, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. H Legg M.D.
ADDRESS (Street, city or town, state): Union Bridge
DATE SIGNED: 11-19-56

PHYSICIAN'S NAME (Type): T. H LEGG
Union Bridge Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: NOV 22-1956
22c. NAME OF CEMETERY OR CREMATORY: BEAVER DAM
22d. LOCATION (City, town, or county): FREDERICK CO. (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: D D Hartzler & Sons
ADDRESS: Union Bridge Md

24a. REC'D BY REGISTRAR DATE: NOV 26 1956
24b. REGISTRAR'S SIGNATURE: Leslie L. Repp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11229 CERTIFICATE OF DEATH

Reg. Dist. No. 11222

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
d. STREET ADDRESS: Duckett Lane, Box 356
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Samuel	Seward	Woolford, Jr.	11	9	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro		2/14/1902	54 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Unknown	Elkridge, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel S. Woolford, Sr.	Matilda Barner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Unknown	Samuel S. Woolford, Jr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Bilateral Pulmonary Tubercul-
002X
DUE TO osis with bilateral cavitations. → 1 Yr.(?)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiac Insufficiency.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 7, 1956, to Nov. 9, 1956, that I last saw the deceased alive on Nov. 9, 1956, and that death occurred at 7.45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. F. Vestal M.D. ADDRESS (Street, city or town, state): Henryton, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): T. F. Vestal Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Hellen Funeral Home Balto. 21	11/10/56	Albert R. Swanborn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11230 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11223 Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr;2mos;12days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marriottsville

3. NAME OF DECEASED (Type or print): First Howard Middle Frederick Last WRIGHT

4. DATE OF DEATH: Month November Day 14 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 26, 1875

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Frederick Wright

14. MOTHER'S MAIDEN NAME: Nell Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 - 3 days.
420.0
DUE TO
(b): Right pulmonary artery embolism — Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9027
DUE TO
(c): Arteriosclerotic heart disease — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S.asso.with circ.disturb.with cereb.arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell out of bed.

20c. TIME OF INJURY Hour: 4:30 p.m. Month, Day, Year: 11/3/56 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town) Sykesville (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Nov.15,1956.

EXAMINER'S NAME (Type): James T. Marsh, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-17-56
22c. NAME OF CEMETERY OR CREMATORY: Mt. View
22d. LOCATION (City, town, or county) (State): Alpha, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F.C.Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: NOV 19 1956
24b. REGISTRAR'S SIGNATURE: C. Harry Heer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S) 5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11231

CERTIFICATE OF DEATH

11224

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster
c. LENGTH OF STAY IN 1b 25 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster R.D. #5

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Uniontown Road

d. STREET ADDRESS Uniontown Road

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First HELEN Middle LOUISE Last YOUNG

4. DATE OF DEATH Month NOV. Day 19 Year 1956

5. SEX female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH NOV. 5, 1905

9. AGE (In years last birthday) 51 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house - wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) New York City N.Y. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Byron Guy Warner

14. MOTHER'S MAIDEN NAME Selena Cross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Mr Carroll F. Young, Westminster Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Months

163X

DUE TO (b) Carcinoma of the lung — 1 year +.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple Sclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1955, to Nov. 19, 1956, that I last saw the deceased alive on Nov. 16, 1956, and that death occurred at 4 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE James T. Marsh M.D. — ADDRESS (Street, city or town, state) 107 E. Main St. Westminster Md — DATE SIGNED 11/20/56

PHYSICIAN'S NAME (Type) JAMES T. MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Nov 23 '56

22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery

22d. LOCATION (City, town, or county) (State) Rural, Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE L. E. Myers Jr., Westminster Md. — ADDRESS

24a. REC'D BY REGISTRAR DATE 11-22-56

24b. REGISTRAR'S SIGNATURE Hazel Mullin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55